

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1.
  - a. Whether there should be reimbursement for date of service 4-17-02.
  - b. The request was received on 7-12-02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60 and Letter Requesting Dispute Resolution
  - b. HCFA(s)
  - c. Medical Audit summary
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60 and Response to a Request for Dispute Resolution
  - b. HCFA
  - c. Medical Audit summary/EOB
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 8-27-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 8-28-02. The response from the insurance carrier was received in the Division on 9-11-02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: Taken from table of disputed services:  
"Reimbursement was not based on coding billed."

2. Respondent: Letter dated 9-10-02:  
 “Per letter dated 6/12/02 from our surgical Re-Evaluation Committee the code of ‘29848’ was used to best describe the procedure performed.”

#### IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 4-17-02.
2. The carrier denied the billed services as reflected on the EOB as “ZHX-001 – THE RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH STATE REGULATED REIMBURSEMENT RATES FOR SUCH MEDICAL SERVICES IN THE PROVIDER’S GEOGRAPHICAL REGION.”

Reaudit dated 6-12-02 states: “Based on the documentation contained in the medical records, we are unable to recommend additional reimbursement for services provided. The re-evaluation of this claim was based on the following: Official Medical Fee Guidelines (‘OMFG’) for the state of Texas Code: 26989. Per our physician advisors code 29848 best describes the procedure performed and the maximum allowable reimbursement was allowed on this code.”

Reaudit dated 7-22-02 states: “Based on the documentation contained in the medical records, we are unable to recommend additional reimbursement for services provided. The re-evaluation of this claim was based on the following: Official Medical Fee Guidelines (‘OMFG’) for the state of Texas Code: 26989. This claim was previously reviewed on 6/12/02. We stand by our previous denial.”

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
4-17-02	26989	\$6,750.00	\$860.00	ZHX-001	DOP	General Instructions (III); CPT Descriptor	<p>The Carrier has denied the disputed service as reflected above.</p> <p>The operative report submitted does not support the code as billed. CPT Code 26989 is a DOP procedure and as such is defined in the MFG, General Instructions as, “DOP is used when the services provided are not specifically listed or are unusual or too variable to have an assigned MAR.” The medical documentation is only supportive that the claimant’s diagnosis was carpal tunnel syndrome and that the Brown Procedure was utilized for intracarpal decompression. The provider’s operative report did not support the unusual or variable circumstances that would have required this code be utilized.</p> <p>Therefore, no additional reimbursement is recommended.</p>
Totals		\$6,750.00	\$860.00				The Requestor <b>is not</b> entitled to additional reimbursement.

MDR: M4-02-4506-01

The above Findings and Decision are hereby issued this 7<sup>th</sup> day of February 2003.

Lesa Lenart  
Medical Dispute Resolution Officer  
Medical Review Division

LL/ll